Louisiana State Board of Medical Examiners

Physical Address: 630 Camp Street, New Orleans, LA 70130
Mailing Address: P.O. Box 30250, New Orleans, LA 70190-0250
Phone: (504) 568-6820, Fax: (504) 568-0503

GRADUATE EDUCATION TEMPORARY PERMIT
QUALIFICATIONS/ INSTRUCTIONS

(Rev. 050104)

(International Graduates Only)

The board may issue a Graduate Education Temporary Permit (GETP) to an international medical graduate (a graduate of a medical school located outside of the United States, Canada, and Puerto Rico) for the purpose of enrolling and participating in an accredited program of postgraduate medical education (residency or fellowship) at a Louisiana medical school, college, or other accredited medical institution.

QUALIFICATIONS FOR PERMIT

- Be at least 21 years of age and of good moral character
- Be a citizen of the United States or possess valid and current legal authority to reside and work in the United States duly issued by the commissioner of the Immigration and Naturalization Service
- Possess a doctor of medicine degree duly issued by a medical school approved by the board. This diploma must be in English; if not in English must be accompanied by a certified translation into English
- Possess a standard Educational Council for Foreign Medical Graduates (ECFMG) certificate
- Have received written commitment from an accredited Louisiana medical school, college or other accredited medical institution formally appointing the IMG to a postgraduate medical education training program which is conducted by such medical school and is not on probation status with the ACGME. This letter must be signed by the director of the program and must be mailed directly to the LSBME.
- Pay the appropriate fee of $200.00. This fee is non-refundable.

GENERAL INFORMATION

The state of Louisiana does criminal background checks as part of the application process through the state -Louisiana Department of Public Safety and Corrections-DOC and Federal Bureau of Investigations-FBI. Materials for this purpose can be obtained by writing to:

LSBME-Attn: CB
P O Box 30250
New Orleans, LA 70190-0250

Or by e-mail at lsbmemat@lsbme.louisiana.gov

Applicants with criminal history may expect delays in the application process.

Certified Birth Certificate

The applicant must submit either a certified birth certificate (a certified document can only be obtained from the issuing agency and must bear the official seal or stamp and signature of an authorized representative) or an original passport (expired passports are acceptable). The certified birth certificate becomes a permanent part of the applicant's file and is not returned. If the applicant submits a passport, the applicant must include a written explanation of the reason the birth certificate is not available.

Valid Visa

Applicants who are not native-born citizens of the United States must show proof of legal entry into the United States to work and reside by presenting either:

- An original certificate of Naturalization
- Certified birth certificate establishing birth to U.S. citizens traveling abroad
- Valid Visa issued by the department of Immigration and Naturalization (INS). (Acceptable visas – J-1, H-1B, Immigrant)

Personal Appearance

A personal appearance with a member of the Louisiana State Board of Medical Examiners (the "Board") or its designee is required of each applicant. Personal appearances are by appointments only and can only be scheduled after receipt of ALL application materials. At the time of the personal appearance, you must present the ORIGINAL of the following documents (copies should have already been provided). All documents submitted to the board must be the original and must be in English. If the document(s) is not in English, they must be accompanied by a translation into English certified by a translator other than the applicant who shall attest to the accuracy of such translation under penalty of the law.

- Medical School Diploma with English Translation
- Marriage license and/or court decree of the applicant who applies in a name different from the name on the medical diploma
- Standard Education Council for Foreign Medical Graduates Certificate (ECFMG)
- Valid Visa

Not later than 24 months following the effective date of an initial GETP, the applicant must have taken and successfully passed step 3 of USMLE.

An applicant holding a GETP cannot engage in the practice of medicine within the state of Louisiana; this permit is for training purposes only.

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MUST BE TYPED *OR* BLOCK PRINTED

ATTACH PHOTO HERE

APPLICATION FOR GRADUATE EDUCATIONAL TEMPORARY PERMIT (GETP)

(International Medical Graduates Only)

This application is for an initial permit only! DO NOT complete this application to renew an existing permit.

Name: Last		**First**		**Middle**		**Suffix (Sr., Jr.)**	**Suffix (MD/DO)**
List all names in which you have ever been known:							
Social Security Number		**Driver's License Number & State**		**One Year Residency to be served:** **From:** **To:**			
Addresses	**Residency Address**	**Name of Hospital & Department**		**City**		**State**	
		Zip + 4	**County/Parish**	**Country if not U.S.**	**Telephone (Area code, #, Ext.)**	**Pager Number**	
	Home Address	**Street & Number**		**City**		**State**	
		Zip + 4	**County/Parish**	**Country if not U.S.**	**Telephone (Area code, number).**		
	Preferred Mailing Address	**Street Number or Post Office Box**		**City**		**State**	
		Zip + 4	**County/Parish**	**Country if not U.S.**	**Telephone (Area code, #, Ext.)**	**Pager Number**	
Identification	**Race**	**Sex**	**Weight**	**Height**	**Eyes**	**Hair**	**Marks**
Birth **(must submit ORIGINAL or Certified Copy of birth certificate)**	**Place**		**Date**		**Are you a U.S. Citizen?**		
	If not native born citizen of the U.S., give the following information:	**Type of visa:**					
		If Naturalized, give certificate number:					
		INS number:					
		Petition number:					
		Date issued:					
		District court through which issued:					
Marital Status	**Spouses First Name:**	**Last Name (if different from yours)**					
U.S. Active Duty	**Branch**	**Dates Served:** **From:** **To:**				**Discharge**	

Education			Post Graduate Training		
High School			**Hospital/Program**		
City, State & Country, if not U.S.			**City, State & Country, if not U.S.**		
Month/Year Started	**Month/Year Graduated**		**Month/Year Started**	**Monty/Year Ended**	**Specialty**
College/University			**Hospital/Program**		
City, State & Country, if not U.S.			**City, State & Country, if not U.S.**		
Month/Year Started	**Month/ Year Ended**	**Degree**	**Month/Year Started**	**Monty/Year Ended**	**Specialty**
College/University			**Hospital/Program**		
City, State & Country, if not U.S.			**City, State & Country, if not U.S.**		
Month/Year Started	**Month/ Year Ended**	**Degree**	**Month/Year Started**	**Month/ Year Ended**	**Specialty**
College/University			**Hospital/Program**		
City, State & Country, if not U.S.			**City, State & Country, if not U.S.**		
Month/Year Started	**Month/ Year Ended**	**Degree**	**Month/Year Started**	**Month/ Year Ended**	**Speci alty**
Professional School			**Hospital/Program**		
City, State & Country, if not U.S.			**City, State & Country, if not U.S.**		
Month/Year Started	**Month/ Year Ended**	**Degree**	**Month/Year Started**	**Month/ Year Ended**	**Specialty**

Practice History and Non-Professional Activity (Do NOT include Training)
Account for ALL time not specified above, in chronological order, from High School to the present.

From MO/YR	To MO/YR	City	State or Country	Employer or practice setting (Clinic, Hosp., Solo/Group, Etc.)	Specialty or Activi ty
/	/				
/	/				
/	/				
/	/				
/	/				
/	/				
/	/				
/	/				
/	/				

States in which license/certificate obtained and basis of licensure/certification

Louisiana State Board of Medical Examiners

P. O. Box 30250, New Orleans, LA 70190-0250
Telephone: (504) 568-6820

To be completed if applying based on reciprocity

VERIFICATION / ENDORSEMENT

Section 1: To Applicant— Complete Section 1 of this form and forward it to the licensing agency of each state in which you have ever obtained licensure/certification, whether permanent or temporary. If necessary, this form may be duplicated.

I hereby authorize the licensing agency of the State of _____to release all information on file concerning me, favorable or otherwise, to the Louisiana State Board of Medical Examiners.

TYPE OR PRINT YOUR FULL NAME	SIGNATURE
LICENSE NUMBER AND DATE ISSUED	ADDRESS
SOCIAL SECURITY NUMBER	CITY, STATE, ZIP CODE

Section 2: **THE SECTION BELOW IS TO BE COMPLETED BY THE VERIFYING/ENDORSING STATE** ***and returned to the Louisiana State Board of Medical Examiners, P.O. Box 30250, New Orleans, LA 70190-0250. This form is NOT to be returned to the Applicant.***

A. This is to certify that the records of the licensing Board of the State of _____indicate that the above-named individual was issued license/certificate No._____ dated_____ on the basis of written examination (state name of examination)_____; reciprocity with the state of _____; other basis (please name)_____.

B. *If State Board Examination,* provide statement of grades or attach hereto.

C. Provide the following:

1. Is this license/certificate current? ..... ☐ Yes ☐ No ☐ Cannot Divulge
2. Is this license/certificate in good standing? ..... ☐ Yes ☐ No ☐ Cannot Divulge
3. Has this individual ever been warned or reprimanded? ..... ☐ Yes ☐ No ☐ Cannot Divulge
4. Has this individual license/certificate ever been revoked? ..... ☐ Yes ☐ No ☐ Cannot Divulge
5. Has this individual license/certificate ever been suspended? ..... ☐ Yes ☐ No ☐ Cannot Divulge
6. Has this individual license/certificate ever been placed on probation? ..... ☐ Yes ☐ No ☐ Cannot Divulge
7. Has this individual license/certificate ever been restricted in any manner? ..... ☐ Yes ☐ No ☐ Cannot Divulge
8. Has this individual ever had any charges filed against him/her? ..... ☐ Yes ☐ No ☐ Cannot Divulge
9. Do you know of any information that may be a discredit to this person? ..... ☐ Yes ☐ No ☐ Cannot Divulge
10. Do your files indicate any derogatory information whatsoever? ..... ☐ Yes ☐ No ☐ Cannot Divulge

REMARKS_____

_____

Date	Signature
	Title
BOARD SEAL	Name and address of licensing agency

NOTE TO BOARD COMPLETING THIS FORM: If answer to 1 or 2 is "No", or 3 through 10 is "Yes", explain and attach certified copies of pertinent material (i.e., Notice of Hearing, Final Decision, Consent Order/Agreement, etc.).

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OATH OR AFFIRMATION

ANSWER THE FOLLOWING QUESTIONS (YES ANSWERS MUST BE EXPLAINED IN SWORN AFFIDAVIT)

		YES	NO
1.	In the five years prior to this application, have you had any physical injury or disease or mental illness or impairment, which could reasonably be expected to affect your ability to practice medicine or other health profession?		
2.	In the five years prior to this application, have you been addicted to or used in excess any drug or chemical substance including alcohol or treated through a drug or alcohol rehabilitation program?		
3.	Have you ever, either as an adult or juvenile, been cited, arrested, charged, convicted or pled nolo contendere to, violation of any: a) State statute?		
	b) Federal statute?		
4.	Has your application for examination or license ever been rejected or denied?		
5.	Have you ever failed a licensure/certification examination? If yes, how many times?_____		
6.	Have you ever been denied membership in a state, county, or local professional society?		
7.	Has your membership in a state, county, or local professional society ever been revoked, suspended, placed on probation, or restricted in any manner?		
8.	Have you ever been denied, had suspended, revoked or restricted, or voluntarily relinquished, staff or clinical privileges in any hospital or other health care institution or organization?		
9.	Have you had any malpractice claims filed, settled or adjudicated against you within the last five (5) years?		
10.	Have you ever voluntarily surrendered, or did you have suspended, revoked or restricted, your narcotics controlled substances license or registration (state or federal)?		
11.	Have you ever voluntarily surrendered, or did you have suspended, revoked, placed on probation, or restricted in any manner, any professional license issued by any licensing authority?		
12.	Have you ever been the subject of any type of disciplinary action or inquiry by any licensing agency, hospital, institution, society, etc.?		
13.	Have you ever agreed not to seek re-licensure in any licensing jurisdiction?		
14.	Have you ever been, or are you currently in the process of being denied, terminated, suspended, refused, limited, placed on probation or placed under other disciplinary action with respect to your participation in any private, state, or federal health insurance program (e.g., Medicare, Medicaid)?		
15.	Has any court determined you are currently in violation of a court's judgment or order for the support of dependent children?		

OATH OR AFFIRMATION OF APPLICANT

I HEREBY swear or affirm that all statements made and information provided in or with this application are true, correct and complete; that I am the person named in the credentials herewith presented and that I am the original and lawful possessor of such documents; that the photograph submitted to LSBME is a true likeness of me and that it was taken within the last 60 days; that in consideration of the issuance to me of a license/certificate to practice in Louisiana, I swear that I shall observe, abide by and uphold the laws of the State of Louisiana governing my practice and that I shall abstain from unethical, deceptive and fraudulent methods of practice and from immoral, unprofessional and unethical conduct, and that I shall not associate professionally with nor become a partner or employee of any person who resorts to such practices. I hereby agree that the violation of this oath shall constitute cause sufficient for the revocation of said license/certificate and surrender of the rights and privileges accorded me thereunder.

Signed _____
Full Name

Subscribed and sworn to before me this _____day

of_____YEAR_____

_____
NOTARY PUBLIC

My commission expires_____

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CERTIFICATE OF DEAN/REGISTRAR

APPLICANT'S NAME

_____

SOCIAL SECURITY NUMBER

_____

Section 1: To Applicant—Complete Section 1 before a Notary. Forward this form to your Medical, Osteopathic, or Podiatry School.

Recent photograph

Passport quality photograph of applicant securely affixed. 2" x 2" clear, front view, full face without hat or dark glasses. Full-length photograph, black and white or computer-generated will not be accepted. Applicant is to sign name across bottom of photograph, partly on photograph and partly upon the page.

Notary is to affix seal directly on photograph.

Affix Photograph Here
(Follow directions carefully.)

I certify that the photograph is a true likeness of _____ (Applicant).

On this the _____Day of _____, 200_____

_____
Notary Public

My commission expires_____

Section 2: To Dean/Registrar of Medical/Osteopathic/Podiatry School

After completion of this form, return to Office of Licensure, Louisiana State Board of Medical Examiners, P. O. Box 30250, New Orleans, LA 70190-0250. DO NOT RETURN TO APPLICANT.

I hereby certify that _____

Whose photograph appears above, was awarded the degree of, or certificate in, _____

Dated _____from this school.

_____ _____
Name of school/program Signature of Medical Dean/Registrar, Allied Program Chairman/Head

_____ _____
Address Title

_____
Date

Affix School Seal Here

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VERIFICATION OF INTERNSHIP OR EQUIVALENT PROGRAM

Section 1: **TO THE APPLICANT--In order to be eligible for licensure in Louisiana, an applicant who is a graduate of a U.S. or Canadian Medical School or college must present proof of having completed at least one ye ar of postgraduate clinical training in a medical internship or equivalent program accredited by the American Council on Graduate Medical Education (ACGME) of the American Medical Association, or by the Royal College of Physicians and Surgeons (RCPS) of Canada and approved by the Board.**

Complete the top section of this form and return it to the LSBME with application documents. The LSBME will then forward this form to the Director of Medical Education or Program Chairman for completion of the bottom section.

To Whom This May Concern at _____:

I am applying for license to practice medicine in the state of Louisiana. This is your authorization to release all information in your files concerning me, favorable or otherwise, to the Louisiana State Board of Medical Examiners.

_____ _____
Print Or Type Your Full Name Signature

_____
Address

_____
City, State and Zip Code

Section 2**: To be completed by the Director of the Hospital or by the Director of Medical Education and returned directly to: Office of Licensure, Louisiana State Board of Medical Examiners, P. O. Box 30250, New Orleans, LA 70130-0250. This form is NOT to be returned to the Applicant.**

Re:_____
(Applicant's name)

This to verify that the records of this institution indicate that the referenced physician served an Internship or Equivalent Program as follows:

Dates of Internship (PGY-1): Start Date:_____; End Date:_____

Type of Internship served: _____Transitional; _____Rotating; _____Categorical (specify specialty)_____

Did the physician successfully complete the Internship? _____Yes; _____No.

Please explain

_____

_____

_____

Date**:**_____ Signed:_____

Title:_____

(Seal of Institution) Name of Institution:_____

Address:_____

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THIRD PARTY AUTHORIZATION

Insert Full Name:

I understand and acknowledge that the submission of an application to, as well as the acceptance or maintenance of, any license, permit, certificate and/or registration (hereinafter referred to as a "license") issued by the Louisiana State Board of Medical Examiners (the "Board") shall constitute and operate as a perpetual authorization by me to each educational institution at which I have matriculated, each state or federal agency to which I have applied for any license, permit, certificate and/or registration, each person, firm, corporation, clinic, office or institution by whom or with whom I have been employed in the practice of medicine or as an allied health professional, each physician or other health care practitioner whom I have consulted or seen for diagnosis or treatment and each professional organization or specialty board to which I have applied for membership, to disclose and release to the Board any and all information and documentation concerning me which the Board may deem material to the consideration of my initial application and during such period as I may hold or maintain a license. With respect to any such information or documentation, the submission of an application to or the acceptance or maintenance of a license from the Board shall equally constitute and operate as a consent by me to the disclosure and release of such information and documentation and as a waiver by me of any privilege or right of confidentiality which I would otherwise possess with respect thereto.

By submitting an application or accepting or maintaining a license issued by the Board, I shall be deemed to have given my consent to submit to physical or mental examinations if, when and in the manner so directed by the Board and to have waived all objections as to the admissibility or disclosure of findings, reports or recommendations pertaining thereto on the grounds of privileges provided by law. I acknowledge that the expense of any such examination shall be borne by me.

The submission of an application or the acceptance or maintenance of a license from the Board shall also constitute and operate as perpetual authorization and consent by me to the Board to disclose and release any information or documentation set forth in or submitted with my application, or which then or at any time thereafter may be obtained by the Board from other persons, firms, corporations, associations or governmental entities, to any person, firm, corporation, association or governmental entity having a lawful, legitimate and reasonable need therefore, including, without limitation, the medical and/or allied health professional licensing, permitting, certifying and/or registering authority of any state; the Federation of State Medical Boards of the United States; professional organizations, associations and societies; the American Medical Association and any component state, county or parish medical society, including but not limited to the Louisiana State Medical Society and component parish societies thereof; the American Osteopathic Association; the Louisiana Osteopathic Medical Association; the Federal Drug Enforcement Agency; the Louisiana Office of Narcotics and Dangerous Drugs, Office of Licensing and Registration, Department of Health and Hospitals; federal, state, county or parish and municipal health and law enforcement agencies and the Armed Services.

I understand that this authorization and consent is valid commencing on the date herein below subscribed and that such will remain in force and effect until and unless I withdraw my application for, or no longer possess or maintain, a license issued by the Board. I also acknowledge that a duplicate of this document may serve as an original.

Signature: _____

Full Name

****TO BE SIGNED IN THE PRESENCE OF A NOTARY**

Subscribed and sworn to before me this _____ day

of _____, 20 _____.

_____

Notary Public ***Seal***

MY COMMISSION EXPIRES: _____